

**CERTIFICATE OF MEDICAL NECESSITY  
DURABLE MEDICAL EQUIPMENT**

All of the following information is required in order for medical equipment to be covered. This form must be contained in the recipient's clinical records.

RECIPIENT NAME: \_\_\_\_\_

MEDICAL ASSISTANCE ID NUMBER: \_\_\_\_\_

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**DIAGNOSIS** - INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS EQUIPMENT REQUEST: (an example of this requirement would be a diagnosis of cerebral palsy - problem being unable to ambulate and wheelchair bound)

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**PROGNOSIS:** \_\_\_\_\_

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**HOW LONG IS THIS PROBLEM EXPECTED TO LAST?**

MONTHS \_\_\_\_\_ INDEFINITELY \_\_\_\_\_ PERMANENTLY \_\_\_\_\_

**EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR CONTINUED RENTAL:**

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**EQUIPMENT BEING PRESCRIBED:** \_\_\_\_\_

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**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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**EXPLANATION OF THE EQUIPMENT'S FUNCTION:** (to include identifying information such as brochures and pictures)

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**PROCEDURE CODE(S):** \_\_\_\_\_

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\$ \_\_\_\_\_ \$ \_\_\_\_\_

Purchase Price

Rental Price (per day-week-month-other)

DME PROVIDER NAME: \_\_\_\_\_

DME PROVIDER ADDRESS: \_\_\_\_\_

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DME PROVIDER IDENTIFICATION NUMBER: \_\_\_\_\_

DME CONTACT PERSON NAME: \_\_\_\_\_

DME CONTACT PERSON PHONE NUMBER: \_\_\_\_\_

DME CONTACT PERSON FAX NUMBER: \_\_\_\_\_